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CORRECTIONAL MANAGED CARE  
INTAKE HISTORY AND HEALTH SCREENING

1721640

## I. IDENTIFICATION

NAME: McCollum, Tony OCCUPATION: Driver EDUCATION: High School  
DOB: 04/04/53 COUNTY: McLennan PREVIOUS TDCJ #(s): \_\_\_\_\_

## II. FAMILY HISTORY

1 Blood disease (sickle cell anemia, hemophilia)	YES	<del>NO</del>	18 INH Prophylaxis	YES	<del>NO</del>
2 Cancer	<del>YES</del>	NO	19 Intravenous Drug Abuse	YES	<del>NO</del>
3 Diabetes	<del>YES</del>	NO	20 Kidney Disease	YES	<del>NO</del>
4 Heart Disease	<del>YES</del>	NO	21 Liver Disease	YES	<del>NO</del>
5 High Blood Pressure	<del>YES</del>	NO	22 Mental Illness	<del>YES</del>	NO
6 Tuberculosis	YES	<del>NO</del>	23 Non Intravenous Drug Abuse/Alcoholism	YES	<del>NO</del>
III. PERSONAL HISTORY			24 Peptic Ulcers		
11 D 1 Asthma/Emphysema	YES	<del>NO</del>	25 Rheumatic Fever	YES	<del>NO</del>
2 Back Injury	<del>YES</del>	NO	26 Rheumatism/Arthritis	<del>YES</del>	NO
3 Blood Disease (sickle cell anemia, hemophilia)	YES	<del>NO</del>	27 Seasonal Allergies	YES	<del>NO</del>
4 Cancer	YES	<del>NO</del>	28 Sexually Transmitted Diseases	YES	<del>NO</del>
5 Cavities	<del>YES</del>	NO	29 Smoker	YES	<del>NO</del>
6 Depression/Suicide Attempt	<del>YES</del>	NO	30 Tetanus Immunization Date	YES	<del>NO</del>
7 Diabetes	<del>YES</del>	NO	31 Tuberculosis	YES	<del>NO</del>
8 Drug/ Food Allergies	YES	<del>NO</del>	32 Unprotected Sex w/Multiple Partners	YES	<del>NO</del>
9 Epilepsy/Seizures	YES	<del>NO</del>	33 Other		
10 Glasses/Hearing Aid	<del>YES</del>	NO	IV. OBSTETRIC/GYNECOLOGIC AL HX		
11 Gum disease	<del>YES</del>	NO	1 Date of last menstrual period		
12 Head Injury	YES	<del>NO</del>	2 Number of pregnancies/live births		
13 Heart Disease/Angina	YES	<del>NO</del>	3 History of Problem pregnancy		
14 Hepatitis	YES	<del>NO</del>	4 Date of last pap smear		
15 High Blood Pressure	<del>YES</del>	NO	5 Date of last mammogram		
16 HIV + / AIDS	YES	<del>NO</del>	6 History of birth control methods (IUD, pills, etc)		
Prior HIV Test Date		NO			
17 Homosexual/Bisexual Activities		NO			

A. If YES to any of the above indicate family member or self, give date and treatment received  
② Father, Brother

B. History of hospitalization? ~~YES~~ NO  
 Please list the DATE, HOSPITAL, CONDITION Hillman Hospital

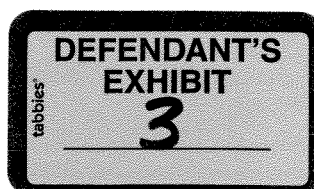
C. Do you have any current medical, mental health or dental complaints? ~~YES~~ NO  
 If yes, what tooth pull, Depression

D. Have you experienced any of these symptoms cough, weakness, weight loss, fevers, night sweats, loss of appetite or lethargy?  
 YES NO If YES, when?

E. What illegal drugs have you used? no  
 What was the mode(s) of use? (Please circle) Smoking Injection inhaled Ingested  
 What amount and how often did you use drugs and alcohol?  
 When was the last time you used drugs or alcohol?  
 Have you ever had withdrawal or seizures when you stopped using drugs or alcohol? YES NO

F. Are you presently taking or supposed to be taking any prescribed medications? ~~YES~~ NO  
 If YES, what See Med Sheet

HSM-13 (6/06)



MCCOLLUM 023

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INTAKE HISTORY AND HEALTH SCREENING

Reason for taking medications									
G	Observations	Tremor	YES	<del>NO</del>	Sweating	YES	<del>NO</del>	Other	
	Condition of skin	Cuts	YES	<del>NO</del>	Bruises	YES	<del>NO</del>		
		Sores	YES	<del>NO</del>	Other				
	Body & Movement	Deformities	YES	<del>NO</del>	Impaired Motor Activity	YES	<del>NO</del>		
		Other							
H BEHAVIOR AND MENTAL STATUS									
Hygiene & Appearance <input checked="" type="checkbox"/> Clean, neat <input type="checkbox"/> Dirty, sloppy <input type="checkbox"/> Other									
Orientation (ask questions and document response)									
What is today's date? 7/15/11									
What time is it? Morning									
What place is this? Hutchins									
Speech <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Loud <input type="checkbox"/> Soft <input type="checkbox"/> Mumbling <input type="checkbox"/> Other									
Attitude <input checked="" type="checkbox"/> Appropriate <input type="checkbox"/> Laughing <input type="checkbox"/> Crying <input type="checkbox"/> Cursing <input type="checkbox"/> Quiet <input type="checkbox"/> Other									
I THOUGHT CONTENT (Please circle YES or NO)									
Are you having current thoughts about suicide or self-injury? YES <del>NO</del>									
Do you see or hear things that others do not see or hear? YES <del>NO</del>									
Do you have any special powers abilities? YES <del>NO</del>									
Do you receive personal messages from the TV or radio? YES <del>NO</del>									
Do you have any phobias or excessive fears? YES <del>NO</del>									
J. DISPOSITION									
Routine referral to		<input checked="" type="checkbox"/> Medical	<input checked="" type="checkbox"/> Mental Health	<input checked="" type="checkbox"/> Dental	<input checked="" type="checkbox"/> CID				
Immediate referral to		<input checked="" type="checkbox"/> Medical	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Dental	<input type="checkbox"/> CID				
Release to general population		<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Other					

Offender Signature	<i>Larry McCollum</i>	Date	7-15-11
Reviewer Signature	<i>10. W. Woodward</i>	Date	7/15/11

*Approved by 7/18/11*

HSM-13 (6/06)

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